MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-8249-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Twin City Fire Insurance Co. c/o Hartford Financial Services Box 27	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 857C 04214

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/20/03	01/20/03	97799-JA	$750.00	
02/24/03	02/24/03	97110	$35.00	
02/28/03	02/28/03	97110	$35.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/11/03 states in part, "…The carrier has denied our charges for procedure code 97110 stating that documentation does not support the criteria for therapy identified in the fee guidelines. Please note that the guidelines regarding the procedure code states 'Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance…' Our charge was for one unit and our documentation supports the criteria set forth by the TWCC MFG. Furthermore, regarding our charge for Job Analysis procedure code 97799-JA, which was denied stating that Box 31 of HCFA does not person rendering service. Dr. B requested this procedure to be done and an employee within our facility fulfilled this requet and is billed correctly for reimbursement per TWCC MFG."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-JA for date of service 01/20/03 denied as "N – Submitted documentation does not support reimbursement for physician/entity noted in box 31 of HCFA. Please resubmit the bill/documentation with person rendering service(s)." The health care provider submitted the Job Assessment Report signed by the technician; per Rule 134.801(e)(4) if services were provided by a non-licensed individual under the direct supervision of a licensed health care provider the supervising health care provider shall submit the bill; however, the Job Assessment report does not specify if the individual was a non-licensed individual and if the licensed health care provider was directly supervising the assessment. Reimbursement is not recommended.

- CPT Code 97110 for dates of service 02/24/03 and 02/28/02 denied as "F – Submitted documentation does not support or meet the criteria for one-on-one therapy that is identified in the fee guideline ground rules and or CPT code descriptor for reimbursement". Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/20/2003	97799-JA	$750.00	$0.00				
2/24/2003	97110	$35.00	$0.00				
2/28/2003	97110	$35.00	$0.00				
				Total Left Column:			$820.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	December 22, 2004
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____